The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit our website at www.iiw.compusysut.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.iiw.compusysut.com or call 1-888-867-9510 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 person/$2,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $25 per person deductible for dental coverage (except preventative care).	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $7,900 individual ($6,120 medical and $1,780 prescription drug) and $15,800 per family ($12,240 medical and $3,560 prescription drug) effective January 1, 2020. For network providers $7,900 individual ($6,120 medical and $1,780 prescription drug) and $15,800 per family ($12,240 medical and $3,560 prescription drug) effective January 1, 2021.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Balance-billed charges, non-covered charges, charges in excess of allowable amounts, and penalties for failure to obtain preauthorization of services. In addition, the cost between a chosen brand and generic equivalent does not count toward the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes (select OAP). See www.CIGNAsharedadministration.com, www.CIGNA.com or at 1-800-768-4695 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Hearing aids must be preauthorized.	You can see the specialist you choose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.iiw.compusysut.com.]

All copayments shown in this chart are taken before your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	Out of network providers covered at 70% coinsurance if outside PPO geographic service area. Applies to covered plan benefits only. See *Plan Booklet* for What is Not Covered. Telehealth or virtual visits are also a covered benefit.
	Specialist visit	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	
	Preventive care/screening/ immunization	No charge.	Not covered – You pay 100% of the charges.	Plan covers preventive services and supplies required by the Health Care Reform law. Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	Applies to covered plan benefits only. No out-of-pocket expense for COVID-19 testing.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iiw.compusysut.com	Generic drugs (Tier 1)	$10 retail; $20 mail order	You pay 100%. You can submit your claim for reimbursement to the Plan's Pharmacy Benefit Manager.	34 day supply retail 90 day supply mail
	Preferred brand drugs (Tier 2)	15% coinsurance.		Plus difference between brand and generic is available. $20 min and $40 max at retail. $50 min and $100 max at mail order 34 day supply retail 90 day supply mail
	Non-preferred brand drugs (Tier 3)	15% coinsurance.		Plus difference between brand and generic is available. $50 min and $100 max at retail. $100 min and $200 max at mail order 34 day supply retail 90 day supply mail
	Specialty drugs (Tier 4)	$75 co-payment.		Only available through mail order. Pre-authorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Physician/surgeon fees			

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 co-payment, then 30% coinsurance after deductible is met.	$300 co-payment, then 30% coinsurance after deductible is met.	Emergency Room co-payment waived if admitted. Contact CareAllies within 48 hours of emergency hospital confinements or first working day after weekend admission, otherwise the Plan will reduce its reimbursements by $200. Applies to covered plan benefits only.
	Emergency medical transportation	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-payment per admission, then 30% coinsurance after deductible is met.	$100 co-payment per admission, then 50% coinsurance after deductible is met.	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Physician/surgeon fees	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible is met.	50% coinsurance for office visits only. All other outpatient services not covered.	Preauthorization is required ($200 reduction in benefits if preauthorization requirement not met for in-network intensive outpatient). Applies to covered plan benefits only.
	Inpatient services	$100 co-payment per admission, then 30%, coinsurance after deductible is met.	Not covered.	Preauthorization is required ($200 reduction in benefits if preauthorization requirement not met including partial hospitalization). Applies to covered plan benefits only.
If you are pregnant	Office visits	No charge.	50% coinsurance after deductible is met.	Applies to covered plan benefits only.
	Childbirth/delivery professional services	$100 co-payment per admission, then 30% coinsurance after deductible is met.	$100 co-payment per admission, then 50% coinsurance after deductible is met.	
	Childbirth/delivery facility services			

[* For more information about limitations and exceptions, see the plan or policy document at www.iiw.compusysut.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance.	50% coinsurance after deductible is met.	Applies to covered plan benefits only.
	Rehabilitation services	$100 co-payment per admission, then 30% coinsurance (inpatient). 30% coinsurance after deductible is met (outpatient).	$100 co-payment per admission, then 50% coinsurance after deductible is met. Inpatient services not covered.	Preauthorization is required for inpatient and speech therapy services ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Habilitation services	Not covered.	Not covered.	You pay 100% of habilitation services.
	Skilled nursing care	$100 co-payment per admission, then 30% coinsurance after deductible is met.	Not covered.	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only. Maximum benefit is 70 days per calendar year.
	Durable medical equipment	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	Replacement only if device is too worn for repair or change in physical condition rendering current device unusable.
	Hospice services	30% coinsurance after deductible is met.	50% coinsurance after deductible is met.	Applies to covered plan benefits only.
If your child needs dental or eye care	Children's eye exam	You pay for charges in excess of $50 maximum calendar year benefit. No charge for preventative care eye exam for children under 19 years of age.		No annual maximum for children under 19 years of age.
	Children's glasses	No charge for lenses. You pay for charges in excess of $150 for frames and $150 for contacts in lieu of glasses.		
	Children's dental check-up	No charge for preventative care dental exam.		

[* For more information about limitations and exceptions, see the plan or policy document at www.iiw.compusysut.com.]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric Surgery	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Infertility treatment	• Private-duty nursing	• Medically Unnecessary Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic services to a maximum of 20 visits per year	• Hearing aids (see Article VI of SPD)	• Routine eye care (see Article VII of SPD)
• Acupuncture services to a maximum of 20 visits per year	• Dental care (see Article VIII of SPD)	• Telemedicine

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage?

This plan or policy does provide minimum essential coverage. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards?

This health coverage does meet the minimum value standard for the benefits it provides. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-432-6636.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-6636.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-432-6636.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-432-6636.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.iiw.compusysut.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist	30%
Hospital (facility)	30%
Other	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$140
Coinsurance	$3,780
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,980

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist	30%
Hospital (facility)	30%
Other	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$310
Coinsurance	$1,420
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,790

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist	30%
Hospital (facility)	30%
Other	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$580
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,880

The plan would be responsible for the other costs of these EXAMPLE covered services.